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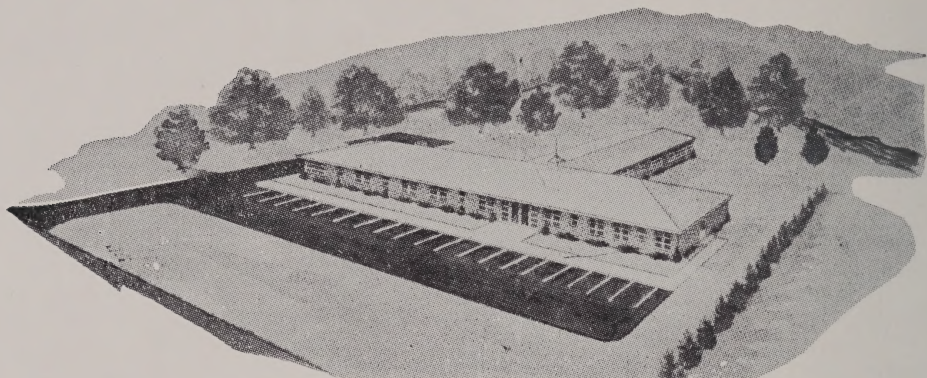


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EDITORIAL

MEDICAL ETHICS AND THE PUBLIC

*"Medicine—The Perfect mixture
of science, art, and ethics."*

—Asaph the Physician
(Sixth century)

Until recently medical ethics were regarded as the exclusive domain and responsibility of the physician. Today, because of the numerous complexities and problems arising from modern biomedical progress, medical ethics has become, or should become, everybody's concern and responsibility. This indeed, was one of the dominant themes of the AMA's Second National Congress on Medical Ethics held several weeks ago in Chicago.

In his address before that Congress James Z. Appel, M.D., a past president of the AMA, urged his listeners as follows:

"As that trend increases, it increases the need to develop, maintain and improve ethical relationships between physicians and many other elements of society — including other physicians, other professionals, allied health workers of many different skills and functions and with the public itself. . . . Closer relationships are inevitable, because medicine obviously is heading down many roads along which it cannot find its way alone."

Up to now, the attitude of the public toward medical ethics has usually been one of indifference, amusement and, at times even, antipathy. The average television viewer seems to go all the way with Ben Casey when he

indignantly exclaims some such line as: "Medical ethics be damned! I'll amputate the patient's medulla oblongata whether the 'chief' approves it or not!"

The recent undue publicity surrounding cardiac transplantation shows that the public is not entirely at fault. After delivering a stinging condemnation of its "circus trappings and glitter," Ivine H. Page, M.D., had this to say at the aforementioned Congress on Ethics:

"What purpose the frantic publicity has served is difficult to discern. Surely it has not been educational. To some of the public, it has been entertaining; to others, revolting. Building of celebrities has been indisputable, with Dr. Barnard and others actively cooperating. Whether it will bring more money for research and a heightened interest in it, no one knows, and, if it does, at what price."

It should be noted that Dr. Page, a noted cardiologist, is the 1968 winner of the AMA's Sheen Award as the Country's outstanding physician.

Now, what can be done to improve our ethical relations with the rest of the world? How can we improve the popular conception of medical ethics? Finally, how can we make medical ethics a collective responsibility? The first step, needless to say, is to set a good example. How can we expect others to respect our standards of conduct if some of our own colleagues seek publicity and breach confidentiality? Worst of all, these colleagues also set a poor example to other members of our profession. We all well remember the international race to the transplant tables with television studios following the high-powered publicity drive of South Africa's Dr. Christiaan Barnard.

Another way to enhance our ethical relations is to participate with clergymen, attorneys, sociologists and others in the community in the search of new principles and in the clarification of old ones. Ethical problems pertaining to organ transplants, artificial insemination, euthanasia and genetic control are even now at our doorstep, and others may well be expected in the near future. To meet the situation, two additional codes were formulated and adopted in the last two years alone (see pages 6 and 8). For the physicians to remain isolated in his ivory tower of old won't do. He must realize that before being a physician, he is a citizen. This last point was emphasized in no uncertain terms at the recent AMA's National Congress on Medical Ethics.

Millman

FROM THE EDITOR'S DESK

After somewhat of a recess, *The Hampden Hippocrat* is resuming with this issue the publication of articles on hobbies of Hampden physicians. See page 21. "A DO-IT-YOURSELF BAHAMIAN OUT ISLAND CRUISE" by Field C. Leonard, M.D. If you have an interesting hobby, we would like to be informed about it.

The Board of Editors of *The Hampden Hippocrat* are most happy to welcome Dr. Robert M. Abrams of Holyoke as an Associate Editor on its staff. It is sincerely hoped that this will be a long and mutually pleasant association.

AMA ETHICAL GUIDELINES FOR CLINICAL INVESTIGATION

At the 1966 Annual Convention of its House of Delegates, the American Medical Association endorsed the ethical principles set forth in the 1964 Declaration of Helsinki of the World Medical Association concerning human experimentation. These principles conform to and express fundamental concepts already embodied in the Principles of Medical Ethics of the American Medical Association.

The following guidelines as adopted by the House of Delegates, American Medical Association on November 30, 1966, enlarge on these fundamental concepts and are intended to aid physicians in fulfilling their ethical responsibilities when they engage in the clinical investigation of new drugs and procedures.

1. A physician may participate in clinical investigation only to the extent that his activities are a part of a systematic program competently designed, under accepted standards of scientific research, to produce data which is scientifically valid and significant.

2. In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.

3. In clinical investigation primarily for treatment—

- A. The physician must recognize that the physician-patient relationship exists and that he is expected to exercise his professional judgment and skill in the best interest of the patient.

- B. Voluntary consent must be obtained from the patient, or from his legally authorized representative if the patient lacks the capacity to consent, following:

- (a) disclosure that the physician intends to use an investigational drug or experimental procedure,
 - (b) a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits,
 - (c) an offer to answer any inquiries concerning the drug or procedure, and
 - (d) a disclosure of alternative drugs or procedures that may be available.

- (1) In exceptional circumstances and to the extent that disclosure of information concerning the nature of the drug or experimental procedure or risks would be expected to materially affect the health of the patient and would be detrimental to his best interests, such information may be withheld from the patient. In such circumstances such information shall be disclosed to a responsible relative or friend of the patient where possible.

- (2) Ordinarily, consent should be in writing, except where the physician deems it necessary to rely upon consent in other than written form because of the physical or emotional state of the patient.

- (3) Where emergency treatment is necessary and the patient

is incapable of giving consent and no one is available who has authority to act on his behalf, consent is assumed.

4. In clinical investigation primarily for the accumulation of scientific knowledge—

A. Adequate safeguards must be provided for the welfare, safety and comfort of the subject.

B. Consent, in writing, should be obtained from the subject, or from his legally authorized representative if the subject lacks the capacity to consent, following:

(a) a disclosure of the fact that an investigational drug or procedure is to be used, (b) a reasonable explanation of the nature of the procedure to be used and risks to be

expected, and (c) an offer to answer any inquiries concerning the drug or procedure.

C. Minors or mentally incompetent persons may be used as subjects only if:

(1) The nature of the investigation is such that mentally competent adults would not be suitable subjects.

(2) Consent, in writing, is given by a legally authorized representative of the subject under circumstances in which an informed and prudent adult would reasonably be expected to volunteer himself or his child as a subject.

D. No person may be used as a subject against his will.

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SUPERVISION OF EXPERIMENTAL SUBJECTS:

RECOMMENDATIONS OF THE ROYAL COLLEGE OF PHYSICIANS

The following are the conclusions and recommendations in the report of a committee of the Royal College of Physicians of London. This committee, under the chairmanship of Sir Max Rosenheim, the President, was set up in September, 1966; its report was published in *The Lancet* 2:357 (Aug. 12), 1967.

1. The planning and conducting of clinical investigations demand skill, experience, and judgment. Difficult ethical problems occasionally arise, and even the most experienced workers would often welcome the opinion and advice of their peers.

2. The competent authority (e.g., board of governors, medical school council, hospital management committee, or equivalent body in non-medical institutions) has a responsibility to ensure that all clinical investigations carried out within its hospital or institution are ethical and are conducted with the optimum technical skill and precautions for safety. This responsibility would be discharged if, in medical institutions where clinical investigation is carried out, it were ensured that all projects were approved by a group of doctors including those ex-

perienced in clinical investigation. This group should satisfy itself of the ethics of all proposed investigations. In non-medical institutions, or wherever clinical investigation (i.e., any form of experiment on man) is conducted by investigators with qualifications other than medical, the supervisory group should always include at least one medically qualified person with experience in clinical investigation. The committee deliberately refrains from formulating precise rules for supervision, because the way in which this could best be organized must vary with different institutions. Owing to the variety of investigations and the importance of not discouraging the proper acquisition of knowledge that may prove useful in caring for the sick, each project must be considered separately.

3. Procedures involving interference with normal function in volunteers carried out for purposes of education rather than investigation (e.g., the use of drugs in student practical classes) pose special problems because of the student-teacher relationship and should be subject to the same supervision.

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THE PROBLEM OF JUDGMENT

by Charles Warren Barnes, Ph.D.

Member, HDMS Medico-Religious Committee

"Here come d' Judge" is a line directly from the Rowan and Martin "Laugh-In", but the question of judgment is a delicate problem for those who find the health and welfare of others given to their care and keeping. Judgment, in the typical sense, is something imposed from without; both those who are judged and those who render judgments feel or sense the factor of *imposition*. I can remember the first model auto kit that my son attempted. It was important that he be responsible for the assembly and what emerged was a vehicle unlike any others known to man. While he had a sense of power and accomplishment in the product, it was a hopelessly inadequate image of what was called to be. Tenderly, I made comments about his model, wishing somehow that he had sought a wider consultation. Any near-approaches to an honest judgment of his masterwork struck tones of alienation and estrangement. He wanted my commendation but not my consultation, he hoped for my approval, but not my evaluation. Judgment activates all of the systems of defense. Even the most subtle observations, if they qualify as judgment, can be devastating.

DIAGNOSIS vs. APPRAISAL

From the perspective of one who deals with the whole man in his context, I am struck by the relationship

of judgment to diagnosis. With the rapid technological advances of medical science in our era, diagnosis has come to mean making a kind of judgment. The very term *diagnosis* may be very inappropriate, even though those of us in psychological fields still speak of the *diagnostic interview*. Diagnosis implies individual judgment, a kind of one-dimension pin-pointing of causes and conditions. A far more appropriate term would be *appraisal*. Those who hear the word know almost immediately what is implied—a team evaluation, a sharing of the responsibilities of judgment. Appraisal of a patient would imply something that diagnosis does not; namely, a sharing of all available information and opinions and conclusions about the person. It would be as interested in the resources of the person in question as the facts about him, as equally concerned with the dynamics of his own individuated process as the content of data on the bedside chart.

APPLICATION

There is yet another significant implication about judgment in *appraisals*. I hear medical friends speak often of the significance of the factor when appraisals can be shared with the patient. When this sharing is part of the healing relationship, then the person does not sense that a judgment has been *imposed* on him from without.

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Even when it is threatening to the person to consider the medical evaluation, there is still the noticeable difference that the patient is sharing in the judgment to be made. He is not likely to be alienated from those who professionally attend his condition, and his self-defenses are more likely to be at rest. In a good psychological sense, a person's capacity to accept and assimilate appraisals, with perception about their immediate relevancy, makes for maturity and strength. Judgment by the therapist is to be seen as alien imposition, not exactly structured to bring the inner response of acceptance and initiative.

What, then, of this business of judgment and the professionals who render judgments? It is easy to fall into patterns of professional functioning where we issue and impose judgments daily and routinely on a variety of persons. The people I meet want to divide their physicians into two kinds, those who with *ex-cathedra* assertiveness announce what is and is to be, and those who bring a native desire for the widest possible appraisal to the moment's need. Speech about the former always bear some trace of alienation; words about the latter suggest that the patient sees his doctor as a concerned and cautious friend who is wise enough to acknowledge the limits of his own view in the light of the risks involved. The former make judgments, the latter demand discriminating appraisals.

If every clergyman is aware that he is not the patient's physician, is it not just as obvious that every doctor is not the patient's only counselor? Both

professions have a whole background of information about any given individual, gained under a wide variety of circumstances. It would seem that any worthwhile appraisal should include all of the available data—the marital problems, the personal crises, the vocational disturbances, the distorted inter-personal relationships, as well as the medical argot and terminology. To this, most of us answer "yes," but the seasons go by and patients come and go and die and still the clergyman and the physician make their separated judgments.

I do not believe that all, or even the majority of clergymen, are adept at evaluating the dynamics at work in the life of a given person including the pressures and the problems that function to the detriment of health, but many clergy are now trained to do so. Increasingly, seminaries require of all graduates at least one summer (in some cases, two) of clinical training in a psychiatric institution. If such men develop the tools of perception, how valuable they could be to the physician in his *appraisal* of the person recently come or returned to his care.

One final point summarizes all others. The appraising mind asks questions, but it must ask all of the questions, not just the questions asked by that particular mind. According to dictionaries of current English usage, *pronouncement* is the most common definition of judgment, and *appraisal*, its sixth possible variation. Because we deal with persons, it would be wise to begin a reversal of that understanding.

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NOT BY MEDICINE ALONE

by Leroy J. Kendrew, M.D.

Chairman, HDMS Medico-Religious Committee

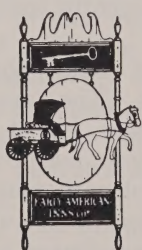
The changing pattern of medical practice has been no exception in the changing world of today. Stereotyped methods used in the investigation of disease have been augmented by the ever expanding technological advances in allied fields. It is to medicine's credit that it has not only accepted, but eagerly sought the help of such progress and has incorporated the newer techniques to its advantage. This has resulted more and more in bringing into the active medical fold such previously essentially foreign fields as electronics, engineering and medical physics. The results are self-evident. Accuracy and speed of diagnosis is at an all time high with the horizon holding promise of even more advancement. It is heartening to see

American medicine not only accept, but eagerly seek all the help that it can get in the advancement of its time honored profession.

However, some sober reflection is necessary to determine whether our efforts have been as consistent in the treatment of disease as they have been in its detection and diagnosis. Can we feel that we have not only accepted, but sought out every possible source of aid in the treatment of illness? Since the goal of every physician is the cure of the patient, it stands to reason that not only must the medical profession seek and accept all the detection help it can get, it must also seek all the therapeutic aids which are available.

Let us be specific. Can we feel se-

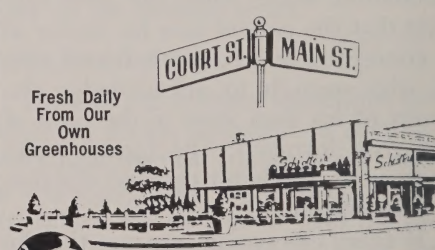
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I know all too well that with the pressures of medical practice today and particularly because of its specialization, such detailed personal knowledge is practically impossible for the physician to obtain by himself. True the family physician may be aware in whole or in part of many of the spiritual facets of the patient's life. Many however, are known only to one's spiritual counselor. Might it not be, therefore, incumbent upon us to seek out such counselor, not with the object of possessing ourselves of the revealed intimacies of the patient's life situation, but to enlist his or her aid in counselling with our patient and her family so that all the emotional and spiritual help available is enlisted for our patient's welfare?

Your Medico-Religious Committee feels that a closer liaison should exist between the medical profession and religion in order to bring these benefits to our patients and continues in its efforts to achieve this goal. We enlist your support.

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A MESSAGE TO THE HAMPDEN DISTRICT MEDICAL SOCIETY

from JOHN W. SPELLMAN, M.D.

Chairman, Committee on Ethics and Discipline, Mass. Medical Society

The Committee on Ethics and Discipline of the Massachusetts Medical Society was established almost one hundred years ago. During that time the Committee has established rules of procedure in acting upon complaints involving charges of possible unethical conduct on the part of Fellows of the Society. In a general way, these guide lines have worked very well. Many of the complaints are based on misunderstanding due to a failure of communication between the physician and the complainant. Fortunately very few instances of a violation of the Principles of Ethics of the American Medical Association and the Massachusetts Medical Society occur.

However, while not unethical, there are many instances of poor judgment, bad manners, and callous behavior which diminish the image of the medical profession and result in poor public relations.

As the practice of medicine changes, so do the problems which come to the attention of the Committee. Currently we have complaints against physicians who refuse to take care of patients on welfare programs. One such instance was that of a physician who rejected as a patient an elderly retired nurse. She was hurt and humiliated when his secretary announced that welfare cases were not accepted. While it is true that a physician may choose whom he will serve, it is also apparent that if a significant number of doctors refuse such patients, the Government will find some way of compelling them to do what they would not do voluntarily.

This problem poses a present and serious threat to the traditions of the medical profession which have always been based on the principle that the needs of the patient are paramount and take precedence over convenience and financial gain to the physician.

THE HAMPDEN HIPPOCRAT

HAMPDEN CAPSULES

Dr. Daly spoke at St. Thomas' Woman's Club in West Springfield on "Inner Conflicts of Man."

Dr. Visconti spoke to the Holy Trinity PTA on how housewives can be kind to their own hearts and those of members of their families.

Dr. Niemiro spoke at the Northeast Proctologic Conference in Jamaica on "Use of Solidified Carbon Dioxide in Proctology."

Dr. Shuman spoke at the Springfield Technical Community College on reading disabilities.

Drs. Silva and Plotkin spoke on Family Centered Care at Eastfield Mall.

HOT FLASHES

Dr. Dasco has passed his boards in Neuro-Surgery.

Dr. Borenstein was named recipient of the 1968 "Amudim" Award of Torah Umesorah, the National Society of Hebrew Day Schools.

Dr. Ayres and Dr. Cummings, Chairman of the Disaster Medical

Care Committee, participated in the Civil Defense Emergency Training Session held at the Springfield Municipal Auditorium on Nov. 14th.

The new Blood Bank will begin operation at the Springfield Municipal Hospital on Dec. 2. Dr. Sullivan has been working hard on the opening.

Dr. John Turner moderated an all day conference on the use of radioisotopes at Wesson Memorial Hospital.

Dr. Suzor, Chairman of the Public Relations Committee, hosted an evening for the news media at his home to introduce the Drug Abuse Program planned by the HDMS. Twelve physicians have volunteered their services up to now. If you are interested, please notify the Society's headquarters.

The plans for the Health Fair, '69—"Your Health, Your responsibility"—are progressing. A press conference is planned for Dec. 4 at 1:30 P.M. to introduce the fair to the public. If you are interested in volunteering some of your time, please contact headquarters or Dr. Walter S. Mozden.

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Robert Salwen, M.D.
1911-1968

Dr. Robert Salwen of 51 Woodbridge Terrace, South Hadley, died at the Deaconess Hospital, Boston, on November 11, 1968.

Born in Brooklyn, N. Y., on November 3, 1911, Dr. Salwen graduated from Lehigh College in 1932 and received his doctorate in medicine from the Boston University of Medicine in 1936. He interned at the Coney Island Hospital in Brooklyn, N. Y., from 1936 to 1938 and then went on to postgraduate training in surgery at New York University from 1938 to 1940. After being discharged from active duty in the U. S. Army Medical Corps in 1946, he went on to serve a residency at the Kennedy General Hospital in Memphis, Tenn. Upon completion of same in 1948, Dr. Salwen came to Holyoke, where he practiced his specialty of urology until his demise.

Dr. Salwen served on the medical staffs of the Holyoke Hospital, the Providence Hospital, the USVA Hospital in Leeds, and the Holyoke Soldiers Home. He was a fellow of the American College of Surgeons as well as a member of the AMA, MMS, HDMS, the Northeastern Section of American Urological Association, and the Springfield Academy of Medicine.

Deepest sympathy is hereby extended to his family and to his many friends and associates.

MARK YOUR CALENDAR NOW!

HDMS MEETING, FEBRUARY 4

HDMS EXECUTIVE COMMITTEE MEETING, JANUARY 21
AND FEBRUARY 18

MMS COUNCIL MEETING, BOSTON, FEBRUARY 12

AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS, NEW YORK,
JANUARY 18 - 23

AMERICAN SOCIETY FOR SURGERY OF THE HAND, NEW YORK,
JANUARY 17 - 18

MMS ANNUAL MEETING, BOSTON, MAY 20 - 22

AMA ANNUAL MEETING, NEW YORK, JULY 13 - 17

A CRUCIAL TURNING POINT?

The National Association of Blue Shield Plans took on the challenge of providing comprehensive coverage for essentially all expenses of health care in a dramatic fashion at its Special Meeting in Chicago on October 8, 1968. Culminating 2 years of study by its Special Study and Planning Committee, the NABSP amended its Membership Standards as follows:

"Each active member Plan shall make available a paid-in-full program, based upon the usual, customary and reasonable charges of physicians and which takes into consideration the patterns of charges for similar services provided under comparable circumstances in the same geographic area. Such programs shall show evidence of professional support; shall contain provision for the development and maintenance of individual physicians' charge patterns; and shall have regular professional review and analysis consistent with Plan responsibility to both physicians and the general public."

In recommending the amendment, the Reference Committee pointed out that Blue Shield has striven to deliver full payment on a national basis. However, "the permissive approach has not achieved that goal, nor does it promise to do so in the immediate future. The need for a national program of true predictability, reflecting local medical practices, is too urgent to permit indefinite delay. A mandatory approach, therefore, is necessary."

COMPREHENSIVE CARE.

As a corollary to the above action, the NABPS adopted a comprehensive scope of benefits program which should be made available by member Plans not later than April 1, 1969. The items listed are as follows: surgery, including routine pre- and post-opera-

tive care and assistant at surgery; anesthesia services; radiation therapy—in and out of the hospital; diagnostic X-ray in-hospital; laboratory and pathology in-hospital medical care, including concurrent care; pulmonary, tuberculosis, mental disorders, drug addiction and alcoholism; obstetrical care, emergency treatment for accidental injury; consultation;

Out of hospital diagnostic X-ray and laboratory and pathological service; physical therapy; home and office; newborn care; physical examinations, out-patient psychiatric care; inhalation therapy; ambulance; prosthetic appliances and orthopedic braces; rental or purchase of durable equipment; private duty nursing; drugs, dental, and vision care.

In the Reference Committee's report on the comprehensive program, it was emphasized that "there is no implication that all programs, national or local, will or should incorporate all of the benefits listed, nor that the availability of a comprehensive scope of benefits will necessarily alter a Plan's usual coverage."

"Neither is there immediate concern with the specific form in which the benefits are marketed, in terms of co-payment or deductibles. These are items which will have to be worked out case by case with specific purchasers, with reverence to their own desires and economic capacities."

During the hearings before the Reference Committee, there was considerable discussion relative to providing and paying for certain of these benefits. However, it was pointed out that all the benefits are already being provided by some Plans and others are about to offer same. Moreover, it was flatly stated that comprehensive coverage, especially those services which would reduce in-patient care

through office and home care, have the support of the medical profession. More important, the general consensus implied that this action was made mandatory "to meet the demands of the market."

PROGRESS AND FORESTALLMENT

The leadership of the NABSP confidently feel that a new era of growth, strengthened relations with medicine and solid public support is in the offing with the adoption of these principles. However, they are also the first to admit that it will take hard and persistent persuasiveness to garner strong medical involvement and support. Physicians will have to be

convinced of the "freedom, flexibility, and local direction inherent therein." Moreover, "physicians will have to recognize their obligations in their charging practices and in providing professional analysis and review." It is further believed that when this program pays a greater share of health care expenses, the desirability of voluntary financing will be enhanced and federal involvement deterred.

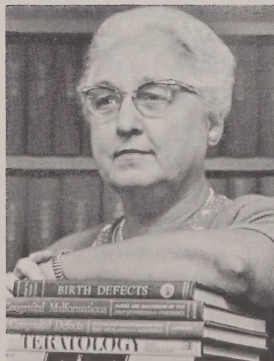
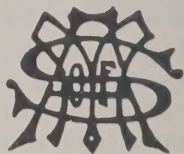
Undoubtedly, the NABSP has taken a historic step. Whether this means progress and forestallment of further and greater governmental intervention in the health care field, only time will tell.

Ayres

THE NEXT MEETING OF THE SPRINGFIELD ACADEMY OF MEDICINE

will be held on

TUESDAY, JANUARY 14, 1969 AT 8:30 P.M.



SPEAKER: VIRGINIA APGAR, M.D.
Vice-President of Medical Affairs
National Foundation, March of Dimes

TOPIC: "HEALTHY BABIES"

CLINIC: Wesson Maternity Hospital, 5:00 P.M.

THE HAMPDEN HIPPOCRAT

NOVEMBER

EXECUTIVE COMMITTEE MEETING

HIGHLIGHTS

The November meeting of the Executive Committee was held on the 19th at 8 P. M. in the Society's conference room. President Barnes called the meeting to order promptly on a quorum of six. Present were: Drs. Barnes, Stoler, Boivin, Anton, Moore, Hough, Beauchamp, Jr., Suzor, Baker, Sullivan, Kelly, Mozden and Mrs. Purdy.

The minutes of the September meeting were read by Dr. Stoler and approved. The account of October's unofficial meeting was read.

COMMUNICATIONS

A letter of thanks from Mr. James White, Director of the Springfield Model Cities Agency, was read relative to the appointment of Dr. Sheffield as representative to the Technical Advisory Pool Committee. Mrs. Purdy gave a verbal report on the status of health planning of the Model Cities Agency. Dr. Ellison, a dentist has been assigned as a paid employee of the program.

The report of the meeting with the Connecticut Valley Health Planning Council and Dr. Lium has been sent out to the membership.

A letter was read from Mr. Franklin, Executive Director of the Springfield Headstart Program, explaining the new rules set up by the Dept. of Public Welfare for pediatricians and general practitioners in regard to payment for Medicaid patients.

A letter from Mr. Frayser of the Springfield Action Committee asking Dr. Barnes to attend a meeting arrived too late for him to attend. A telephone call was made to Mr. Frayser explaining the reason for not attending and offering any help in the future.

Dr. Robert M. Abrams, at Dr. Ayres suggestion, was appointed as an Associate Editor to *The Hampden Hippocrat*.

OLD BUSINESS

Dr. Shuman has appointed Dr. Plotkin to serve on the Professional

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Advisory Committee of the Visiting Nurses Association as a pediatrician. The Committee approved.

Dr. Suzor gave the report of the Public Relations Committee. The points taken up by this Committee were:

1. The importance of the Emergency Medical Service.

2. Reporting some cases of the Grievance Committee to the news media.

3. Developing good public relations with the news media.

4. Keeping the Speakers' Bureau active, especially on "Drug Abuse," to schools, teachers, parents, etc.

5. The Health Fair, '69.

The report of the Public Health Committee was read. Funds will be

sought for the Fair by Dr. Moore, Treasurer.

Mrs. Purdy gave a report on the activities at headquarters. Thirteen committee meetings were held in the Society's conference room. The movies owned by the Society are in constant use, and physician members have been most generous with their time in speaking to various PTA and church groups. Mrs. Purdy has attended meetings of the Visiting Nurses Association, the Human Development Task Force and Model Cities' Health Planning Task Force.

The meeting was adjourned at 9:15 P. M. The Grievance Committee met and heard three cases. Appropriate letters will be written. This meeting was adjourned at 10:22 P. M.

Luncheons — Dinners — Cocktails

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A DO-IT-YOURSELF BAHAMIAN OUT ISLAND CRUISE

by Field C. Leonard, M.D.



The Delilah off Rose Island

"Probably the most exquisite cruising ground in the Northern Hemisphere"—"Incredibly beautiful anchorages, land-locked harbours"—"Wild uninhabited beaches and coves"—sounds like a travel brochure, but these phrases were lifted from our *Yachtsman's Guide to the Bahamas*. They prove to be no exaggeration, though the *Guide*, which was to become our navigational bible, proved to be about as unreliable as a real bible so far as navigational aid was concerned. On our trip, we grounded at least six times and missed as many landfalls. At least, as a proper bible should, the *Guide* got us home safely. The Out Islands are all those other than New Providence, the capital island, in the Bahamas. My wife and I and our ten year old daughter, accompanied another sailing couple for

two weeks of cruising the Exumas last spring. I am writing this with the log of the *Delilah* before me. *Delilah* is a thirty foot fiberglass auxiliary sloop of the California class; that is, she is a cruising sailboat with one mast and two sails, with a small gas engine for emergencies or when the wind dies out. She sleeps six in two cabins. Although both couples own their own slightly smaller boats, to get these to and from the Bahamas would be a logistical nightmare and waste of valuable vacation time. We, therefore, took command of the *Delilah* as a so-called "bare-boat charter"—rented and without captain or crew—in Nassau.

Having only two weeks, we decided to limit ourselves to the Exumas, a chain of over three hundred coral islands, or keys (spelled cays). The Exumas extend south over a hundred

miles from New Providence toward Cuba. They range in size from that of a small backyard, to several miles in length. Here we found ourselves pretty much alone except for occasional native fish and conch boats, and the rare cruiser, like ourselves; there is no Coast Guard to call on the radio phone or Navy or even navigational markers; there are constantly shifting sand bars in this birth place of hurricanes, mostly uninhabited and uninhabitable islands, and *no ice*. You navigate by the seat of your pants, and you drink your rum warm.

Our first run across Yellow Bank at the top of the Tongue of the Ocean, was a wild one over open ocean about sixty miles from Nassau to the Exuma chain. We started around ten in the morning. Before noon we were alone and without site of land. Our landfall came about 6:00 P. M., and we did it all using the single number one "jenny" or foresail. Despite such short rig, we were hull-down and rail awash. We estimated the winds as Beaufort Force Seven (tops of waves blown off, about 35-40 MPH, or so-called "moderate gale".) I dare say we were making 8-10 knots. There was no taff-rail log to tell exactly how fast we ran. We proceeded at sundown to run aground on a sandbar at the entrance to a beautiful private cove on an uninhabited island, which one we knew not. Next day we figured out we were at Pidgeon Cay, which is twenty-five miles down the Exuma chain. That moderate gale had really moved us. We had as charts only data reprinted from British Admiralty observations of 1873. That's right, no new chart data since the days of the pirates. Turner's aerial photographs are available, but we weren't exactly flying. Besides, we didn't have them.

NAVIGATION HAZARDS

Coral islands is "eyeball" cruising. One needed to be constantly aware of

changes in the color of the water. This meant posting a forward lookout, preferably wearing polaroid glasses, and making a point to run always with the sun behind us. The water in the Bahamas is so clear—too warm for the growth of plankton—that you can't tell whether its three feet or over twelve feet looking straight down. Looking ahead, however, "blue water" proved to be over twelve feet, "green water" in-between, and "white water" is under three feet. Since our boat drew four and a half feet, all this was a matter of some importance.

A constant threat also are the millions of "coral heads" that pepper the navigational routes like seeds of disseminated malignant melanoma in the tissues of the ocean. These are submerged brownish colored submarine knolls of jagged coral about the size of a two-story house. You see them, and you go around them, or else. Hand-signalling a zig-zag course through a garden of coral heads can become nerve-wracking.

Sandbores or bars stand out like long fingers from east-to-west up to five miles in front of most of the islands. These are formed the way silt deltas are formed before river estuaries by the prevailing currents and winds that come through the island chain from the eastern or ocean side. Travelling south (or north) therefore, as we were to do, on the Tongue of The Ocean or sound side of the Exumas, one must either go out around each bore or chance it and cut across. Sometimes it was necessary to go over ten miles out and around a bore to get from one cay to another only a half mile apart. In the cut or "rage" between two cays, the white foam of crashing ocean waves is a spectacular sight. There is a tendency to cut across, or shave the sandbore, because standing out too far around them can make it impossible to recognize an island silhouette and know

where you are. It was easy to lose count of the islands going south and returning north, and we often did. At first alarmed, we learned to laugh at this. We were beginning to learn the pleasures of *not* knowing exactly where we were.

AGROUND

Delilah had no depth finder, and we fashioned our own lead by tying a rusty wrench to a length of line. With this we "heaved the lead" and called out our soundings by hand, just like Mark Twain.

In all, we must have run aground at least six times. Drawing four and a half feet, our boat was really too deep for this area. We'd have been much

and not jagged coral that is hit, striking bottom at high or low water enables you to get off just as you went on. Grounding on a rising tide is no problem since you'll float off just by waiting a few minutes. The unfortunate time to strike bottom is on a falling tide. If frantic efforts with reversed engine, anchors, and winches don't get the boat off at once, it becomes necessary to hang up for six hours plus awaiting a whole cycle of tide. In the meantime, the boat is high and dry and in the case of a deep keel boat, at a very embarrassing angle. I once did this in the dead of night and found myself actually nauseated and dizzy from trying to sleep



The Leonards on the Delilah leaving Nassau

better off with a center-boarder, or a Trimaran. Of course, power boats and houseboats usually draw less than three feet, and can go anywhere down here. We later learned that grounding was standard in the Bahamas and part of the adventure. When you stop and think of it, assuming it is soft sand

on the wall of the cabin. Getting around inside such a careened boat is like mountainclimbing.

WHO SAID SO?

Among the Exumas we missed many landfalls—believing we had arrived at a certain island, only to find

ourselves elsewhere. After a week afloat, we arrived on Easter Sunday at Sampson landfall. It goes like this from the log — "We spotted a yacht flying a burgee that said S.C.Y.C. — Sampson Cay Yacht Club. We walked up the pier and found ourselves staring unbelievably at a sign that said Staniel Cay Yacht Club. We explained as tactfully as we could that the sign should read Sampson Cay Yacht Club, but without avail. Joe Hocher, the Assistant Manager, had been there seven years; his boss, even longer; and the natives, longer still; and they all thought they lived on Staniel Cay. In the face of such overwhelming testimony and desiring for various reasons to remain on good turns with the inhabitants, the first we had encountered since Nassau, we concluded that the chart had put the wrong name on the island and that we had really arrived at an island named Staniel Cay by the natives but Sampson Cay by the chart. Nobody bought this theory either."

LIFE'S PLEASURES

With a small boat cruising mostly uninhabited coral islands in iceless tropics, one might wonder how to maintain body weight and red cell mass. We carried a lot of canned goods, but these we used as fillers for native fish and conch. Incidentally, conch — pronounced konk — are the Al Capp "Schmoos" of the Bahamas. They are available everywhere forming the staple of the diet and making excellent chowder. The secret is long, slow cooking. We also had delicious fresh Red Snapper, Skipjack, Grouper, and Margerite fish, all there for the taking. Rum is cheap and peculiarly just right in the tropics. We drank it with canned fruit juice—warm. Remember the "grog" for sailor's morale during Pax Britannica?

Twice on the trip, huge Manta Rays, travelling in pairs, undulated

under our keel like huge submarine magic carpets in the clear water. They had the eerie quality of bats gliding in a ghostly belfrey. Each was the size of a twenty foot tarpaulin—thin, flat, black, and swimming diagonally, like a diamond. They have big flap-like "ears" and stingers in their spine. Once, while swimming in an isolated lagoon, a five-foot shark went right between our legs. He ran off, and so did we. The real danger lies in swimming in water over a grassy bottom. We were told to stick to clear water over sandy bottom to avoid the Barricuda feeding ground and not to go overboard after 5:00 P.M. or before 7:00 A.M.—the dinner hours for these ferocious man-eaters. I saw a Barricuda someone had caught. It was about four feet long, very narrow, almost like a huge eel, and had an elongated narrow underslung lower jaw shaped like a surfboard. There were multiple rows of razorsharp teeth lining the roof and floor of its oversized mouth. I could imagine a whole human biceps in one single tearing bite. We were advised also never to dump our garbage, nor to swim, if bleeding (i.e., menstruating) or with an open sore or if wearing anything flashy such as a watch, ring, or buckle, and to swim in company only.

On a few difficult passages we enlisted a native guide to take us through. We never cruised at night, for obvious reasons, though the natives with their local knowledge and experience often did. Bahamians are extremely friendly and helpful. Talking to them is quite an experience, for they murder the English language in a delightful sort of rape.

With a bit of boating experience and a desire for privacy, peace, and solitude, far from cries of "population explosion," there is no better vacation than a "bareboat" Bahama cruise. Working the boat yourself gives just

*Dr. Field C. Leonard
pointing the way
off Compass Cay.*



enough exercise for the appetite, and a dash of adventure to keep from falling into that sloth, so commonly experienced by Northerners in the tropics. Here there are breath-taking sunsets and sunrises, a steady succession

of sunny skies—at least in April, with moonlit and starry nights, private coves and beaches, pleasant and adventurous sea passages, gunk-holing paradises and the pitch and roll of your own private command.

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music was provided by Art Slade and his orchestra. Everyone who attended even had the opportunity to learn the fun dance—"Alley Cat"—especially, when instructions were given by a very proficient teacher.

Aside from it being a most enjoyable evening, the "White Cap Ball" was also a financial success. The proceeds thereof will provide scholarships for students in nursing and allied medical fields for the academic year of 1969-70.

WHITE CAP BALL '68

The Twin Hills Country Club in Longmeadow was the setting of the Auxiliary's sixteenth annual "White Cap Ball" on November 2, 1968. The Auxiliary members, their husbands and friends all joined together to make this a truly memorable social success.

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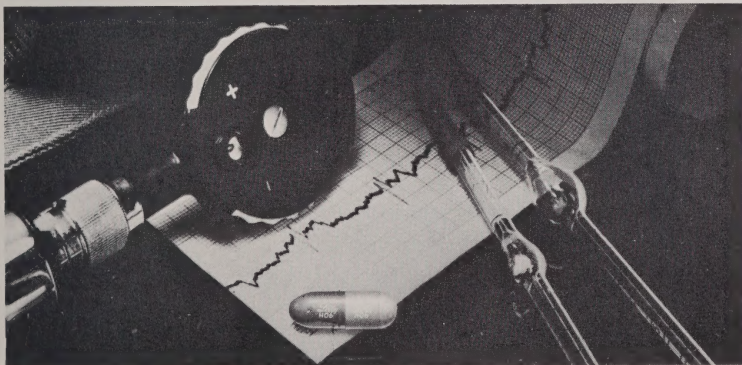
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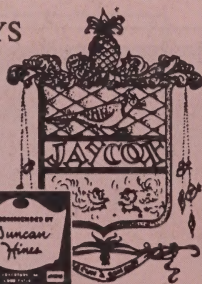
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